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Issue Date: 08 June 2006

Case No. 2004-BLA-6753

In the Matter of

HAROLD D. STEVENS,
Claimant,

v.

CLINCHFIELD COAL COMPANY,
Employer,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

Ron Carson, Lay Representative
For the Claimant

Tracy Alice Berry, Esq.
For the Employer

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER—DENYING BENEFITS

This case arises from a claim for benefits under the "Black Lung Benefits Act," Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq*. (hereinafter referred to as "the Act"), and applicable federal regulations, mainly 20 C.F.R. Parts 412, 718, and 727 ("Regulations").

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to the survivors of persons whose death was

caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lung arising from coal mine employment and is commonly known as black lung.[1]

At a formal hearing held in Big Stone Gap, Virginia on May 11, 2005, all parties presented evidence and argument, as provided in the Act and Regulations issued thereunder, found in Title 20, Code of Federal Regulations. Director's exhibits 1-33, Employer's exhibits 1-35, and Claimant's exhibits 1-3 were admitted into evidence at the hearing. (Tr. 6, 8-29). Employer's exhibits 3, 5, 6, 21, 22, 30 were admitted over Claimant's objections but subject to my review. Specifically, Claimant objected to these exhibits on the basis that they were taken in pursuit of the claim and consequently exceed the evidentiary limitations set forth in 20 C.F.R. § 725.414 (2003). (Tr. 10, 11, 18, 19, 24-25). Employer, however, argued that these exhibits constitute treatment records or rebuttal evidence and are therefore properly admissible under the regulation. Except where otherwise noted below, I find that these exhibits are consistent with, and do not exceed, the evidentiary limitations, and they are therefore admitted into evidence.

The record was held open for thirty days in order for Claimant to review and respond to Dr. Castle's deposition testimony, which appears in the record at EX 35.[2] At the hearing, I requested that the parties submit their written closing arguments within thirty days following their receipt of the hearing transcript. (Tr. 37). I received Claimant's closing argument on June 14, 2005 and Employer's closing argument on July 22, 2005 and the record is now closed.

ISSUES

The contested issues are:[3]

1. Whether Claimant has pneumoconiosis;
2. Whether the pneumoconiosis arose out of Claimant's coal mine employment;
3. Whether the miner is totally disabled due to pneumoconiosis
   (DX 35; Tr. 5).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Procedural History and Factual Background[4]

Procedural History

Claimant, Harold D. Stevens, filed this claim for benefits on October 10, 2003. (DX 2) This is his first claim for benefits. The District Director awarded benefits by Proposed Decision and Order on June 4, 2004. (DX 23) The employer disagreed with the determination and

[1] The following abbreviations have been used in this decision: DX = Director's exhibit; EX = Employer's exhibit; CX = Claimant's exhibit; Tr. = Transcript of the hearing; BCR = Board-certified radiologist; and B = B reader of x-rays.

[2] The transcript was admitted outside the twenty-day rule, provided Claimant was given time to review it. (Tr. 28).

[3] For purposes of appeal, Employer is also contesting the validity and applicability of the revised regulations.

[4] Given the filing date of this claim, subsequent to the effective date of the permanent criteria of Part 718 (i.e., March 31, 1980), the regulations set forth at 20 C.F.R. Part 718 will govern its adjudication. Because the miner's last exposure to coal mine dust occurred in Virginia, this claim arises under the jurisdiction of the U.S. Court of Appeals for the Fourth Circuit. *See Broyles v. Director, OWCP*, 143 F.3d 1348, 21 BLR 2-369 (10th Cir. 1998).

requested a formal hearing on June 10, 2004, and the case was forwarded to the Office of Administrative Law Judges on September 2, 2004 for hearing. (DX 25, 31) I conducted a hearing in this matter on May 11, 2005 in Big Stone Gap, Virginia.

The findings of fact and conclusions of law that follow are based upon my analysis of the entire record, including all documentary evidence admitted, arguments made, and the testimony presented. Where pertinent, I have made credibility determinations concerning the evidence.

Background

At the hearing, Claimant testified as follows: He is 68 years old and last worked for Clinchfield Coal Company for 37.5 years. Tr. 33. He testified that his last work was in construction outside the coal mine. *Id.* Claimant stated that his last job for Clinchfield was as a shuttle car operator, which he did for several years. Tr. 34. He explained that the job required him to haul coal from the mine face to the beltline, eight hours per day and five or more days per week. *Id.* Claimant testified that he worked 30 years inside the mine and thirteen years outside the mine. Tr. 35. He explained that when he worked outside the mine his job entailed opening up the rock hose and unwinding and carrying it. *Id.*

Claimant testified that he was treated by Dr. Robinette, who also performed surgery on the Miner, and he is currently taking medicine prescribed by Dr. Robinette. Tr. 35-36. He testified that he also suffers from Parkinson's disease. Tr. 36. Claimant explained that he could not run a shuttle car now because he gets short of breath. *Id.*

Medical Evidence

Chest x-rays

The record contains the following chest x-ray evidence:

Exhibit No.	Date x-ray	Physician/Qualifications	Interpretation
DX 22	7/10/02	Ahmed/BCR, B	1/1, p/s. Film quality 2 – overexposed, right and left scapula overlay. Impression: Simple pneumoconiosis; emphysema; bullae.
EX 25	7/10/02	Scott/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Film quality 2 – scapulae over lungs. Comments: Right chest surgery – clips in hilum; suture lines; small calcified granuloma right mid-lung; hyperinflation lungs compatible with

			emphysema; healed fracture left 7th rib; ? clothing artifact; ? button left mid-lung; advise repeat.
DX 22	5/22/03	Pathak/BCR, B	1/1. p/s. Film quality 2. Impression: Pulmonary pneumoconiosis; emphysema; honeycomb lung pattern; normal heart size.
EX 23	5/22/03	Scatarige/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Film quality 2 – a capulae over lateral upper lobes. Comments: Improper position. Hyperinflation; aortic arch atherosclerosis; surgery medial right lower lung; CG right mid-lung; scarring right hemidiaphragm; c/w prior surgery; minimal right apical parenchymal scarring c/w healed TB.
DX 10	12/11/03	Baker/B	1/0, p/t. Film quality 2– underexposed, (illegible). Changes in right upper lobe. Question etiology.
EX 24	12/11/03	Wheeler/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Film quality 3 – underexposure/left scapula on lung periphery. Comments: Healed right chest surgery for partial resection right lower lung…; ill defined fibrosis more likely than infiltrate in lateral periphery right apex and RUL; tiny calcified granuloma right lower lateral lung and possibly few below right hilum compatible with healed histoplasmosis; tiny pleural scar tenting eventration right hemidiaphragm dome; moderate diffuse osteoporosis; minimal arteriosclerosis aortic arch. No silicosis or CWP.

CX 1	9/9/04	Alexander/BCR, B	1/1; p,q. Film quality 2 – scapula overlay.
EX 26	9/9/04	Wiot/BCR, B	No parenchymal or pleural abnormalities consistent with pneumoconiosis. Film quality 1. Comments: Not CWP; old granuloma right apex.
CX 2	1/11/05	Cappiello/BCR, B	1 /2; p, s. Film quality 1. Coalescent opacities right upper lung (ax). Chronic obstructive pulmonary disease (em). Residues of previous right thoracotomy.
EX 33	1/11/05	Wheeler/BCR, B	No CWP. Film quality 2.

Pulmonary Function Studies

The record contains the following pulmonary function study evidence:

Ex. No.	Date	Age	Height	FEV1	MVV	FVC	FEV1/FVC%	Qualify?
DX 22	5-22-03	66	66”	1.44	13.5	1.93	----	Yes.

Good effort and cooperation. Interpretation: Testing indicates moderate restriction.

EX 16 5-22-03 This study was reviewed by Dr. James R. Castle who is board certified in internal medicine and pulmonary disease and is a B reader. Comments: This study is invalid and does not represent his maximum physiologic effort because of hesitation at the onset of exhalation and lack of reproducibility. It is my opinion that his true physiologic effort is greater than that represented.

DX 10	12-11-03	67	65 3/4”	2.44	----	3.10	78%	No.

Patient cooperation and comprehension not noted.

EX 15 12-11-03 This study was reviewed by Dr. James R. Castle, who is board certified in internal medicine and pulmonary disease and is a B reader. Comments: This represents a valid study. The forced vital capacity and FEV1 are normal and the FEV1/FVC ratio is very minimally reduced. This study is essentially normal.

DX 22	3-10-04	67	66”	0.95	24.5	1.46	----	Yes.

Good effort and cooperation. Interpretation: Testing indicates severe obstruction as well as low vital capacity, possibly from concomitant restrictive defect.

EX 17 3-10-04 This study was reviewed by Dr. James R. Castle who is board certified in internal medicine and pulmonary disease and is a B reader. Comments: This is a totally invalid study because of inadequate exhalation time, lack of reproducibility, and less than maximum effort. This does not represent his maximum physiologic effort, and should not be considered in determination of disability.

EX 26	9-9-04	68	67"	2.41	39	2.82	86%	No.

Cooperation and comprehension not noted.

EX 31	1-11-05	68	66"	2.05	49	2.48	82%	No.
				*2.21	*--	*2.62	84%	No.

Comments: Valid studies were obtained but effort was variable. Spirometry shows reduced FVC and FEV 1 without large airway obstruction. Total lung capacity is normal. Diffusion is normal.

* = Post-Bronchodilator

Arterial Blood Gas Studies

The record contains the following arterial blood gas study evidence:

Ex. No.	Date	pO2	PCO2	Qualify?
DX 10	12-11-03	102.0	39	No.
EX 26	9-9-04	77.2	43.5	No.
		*90.7	*46.2	No.

Comments: with pulse oximetry.

EX 31	1/11/05	82.3	40.9	No.

Comments: Resting ABGs are normal. Carboxyhemoglobin level is normal.

* = Post-Exercise

Medical Reports

Hospitalization Records and Treatment Notes

The record contains a hospital admission report and discharge summary from Bristol Regional Medical Center from November 14 through 16, 1989. (EX 19) The admission summary indicates that Claimant was admitted to the hospital for GI bleeding. The admitting diagnoses were: 1) GI bleeding post-gastrectomy; 2) Chronic abdominal pain and vomiting, likely functional dyspepsia; 3) Emphysema with barrel chest, chronic cough, dyspnea on exertion and situational depression; 4) Status post total gastrectomy for apparently chronic discomfort including vomiting. The final discharge diagnoses were: 1) Hematochezia of anal origin secondary to large internal hemorrhoids; 2) Anemia, likely from post-gastrectomy and bile reflux gastritis and #1; 3) Chronic abdominal pain and vomiting, likely functional origin; 4) Emphysema with barrel chest, chronic cough, dyspnea on exertion and subsequent situational depression; 5) Status post total gastrectomy for chronic discomfort including vomiting; 6) Markedly positive purified protein derivative without evidence of tuberculosis, other than a densely calcified granuloma in his lung. His liver, urine, and chest are otherwise normal so I do not think antituberculosis treatment is likely to make any difference. However, the purified protein derivative is quite strikingly positive and I am sure somewhat treated. The discharge summary states that a chest x-ray revealed granuloma of the right lower lobe and a PPD skin test was 20mm, reddened and blistered at 48 hours. It indicates that the miner expressed concern over working in low coal, because that is when he gets weak and vomits, and wondered if his current condition would disable him.

The record contains a progress report by Dr. Emory H. Robinette dated November 4, 1992 that appears in the record at EX 14. Dr. Robinette is board certified in internal medicine and pulmonary disease and is a B reader. (EX 4) Dr. Robinette noted that Claimant was referred to him for evaluation of a right middle lobe infiltrate, possible mass effect with increasing right posterior chest pain. He noted that Claimant's illness began two months prior with increasing congestion and cough productive of white sputum. He noted that the cough has persisted and Claimant bitterly complained of recurrent episodes of sinusitis and sinus congestion. Dr. Robinette noted that Claimant worked in the mining industry for 36 years and currently works as a shuttle car operator. He noted that Claimant smoked one pack of cigarettes per day since age eighteen and has a 40-pack year smoking history. From a pulmonary standpoint, Dr. Robinette recorded that the miner complained of right posterior chest pain, increasing cough, some shortness of breath but no left sided chest pain, palpitations, or nausea. Claimant's physical exam was essentially normal but Dr. Robinette noted some evidence of temporal wasting and the presence of some shoddy nodes on the anterior cervical chain. On auscultation, the chest expanded symmetrically with inspiration and expiration, breath sounds were slightly diminished in the right middle lung region but no audible wheezes or bronchospasm were present. He noted that there was marked tenderness of his posterior 8^{th} or 9^{th} rib.

Dr. Robinette noted that a chest x-ray taken October 27, 1992 revealed the lungs were expanded with evidence of a right middle lung density, approximately four centimeters across with an area of central vacuolization compatible with a cavitary lung lesion. He noted that there was evidence of prominent right hilum, and the right hilum was somewhat full with evidence of

a right middle lobe pneumonia. Dr. Robinette's impression was: 1) Right middle lobe pneumonia with evidence of cavitation, rule out possible obstructive endobronchial lesion; 2) Right posterior rib pain, rule out possible cough fracture vs. lytic lesion; 3) History of coal dust exposure with chronic bronchitis type symptoms; 4) Weight loss, unknown etiology; 5) Status post gastrectomy. Dr. Robinette noted that he scheduled Claimant for diagnostic bronchoscopy with possible biopsy of the right middle lung lesion.

Claimant underwent a bronchoscopy on November 4, 1992 at Russell County Medical Center to evaluate a persistent right middle lobe pneumonia. The report appears in the record at EX 8. The report describes the procedure and states that the left tracheobronchial tree shows no evidence of endobronchial lesion, there was minimal bronchial wall pitting present, the right tracheobronchial tree revealed a patent right upper lobe orifice, the right middle lobe orifice was obstructed by an exophytic lesion that appeared to be somewhat calcified, there was necrotic tissue in and around the area and the lesion started approximately 1 cm below the take off of the orifice of the right middle lobe. A biopsy was also performed of the lesion.

A surgical pathology report from Inter-Mountain Pathology Associates, dated November 6, 1992, appears in the records at EX 7. The report is of a biopsy of the right middle lung taken in follow-up of the bronchoscopy. The diagnosis is inspissated mucus with dystrophic calcification, ? broncholith, (illegible) evidence of tissue, clinically bronchial biopsy, right middle lung.

Claimant underwent a right middle lobe lobectomy on November 16, 1992. The operative report and surgical pathology report from Holston Valley Hospital and Medical Center appear in the record at EX 20 and 21. The operative report provides a detailed description of the procedure. The diagnoses in the pathology report are: 1) organizing pneumonia and acute and chronic bronchitis. The comment on the report reveals that the miner's case was reviewed at the weekly surgical pathology conference and the physicians agreed that histologic changes of an organizing pneumonia are present, including bronchiolitis obliterans. An inflammatory infiltrate is noted within the subepithelial stroma in the histologic sections of the bronchus. Remote granulomata are noted within the parabronchial lymph nodes. The physician stated that while all of these findings could be explained by a chronic bacterial or viral pneumonia, there is a surprising amount of fibrosis within the alveolar septae away from the organizing pneumonia. He noted that these findings raise the possibility of an underlying interstitial pneumonitis, although radiographically this should present as a diffuse process. He observed that if there is anything in the clinical history to suggest usual interstitial pneumonia, it may be useful to have these histologic sections reviewed by a specialist in pulmonary pathology. The report indicates that there is no microscopic evidence of granulomatous inflammation, fungal, mycobacterial infection, or malignancy.

The record contains a consultation report by a cardiologist, Dr. Javed, dated July 21, 1993. EX 13. The report states that Claimant was seen for evaluation of chest pain. Dr. Javed's impression was: 1) Chest pain typical of unstable angina. Pressure like retrosternal chest pain radiating to the left arm. Episode of severe chest pain was associated with irregular ischemia though ischemic changes had not been noted on EKG. So far there is no evidence of myocardial infarction. 2) Right carotid bruit due to carotid stenosis. 3) History of hypertension.

The record contains a pulmonary function study test from the Russell County Medical Center interpreted by Dr. Robinette and dated December 22, 1993. EX 22. The test is part of the miner's medical treatment and not submitted or taken for purposes of this claim. Dr. Robinette's impression was essentially normal spirometry.

An echocardiogram report dated January 17, 1994 appears in the record at EX 12. It was taken at Russell County Medical Center and the impression is: 1) Mild to moderate left ventricular dysfunction consistent with inferior, septal and apical myocardial infarction; 2) Mild mitral regurgitation; 3) Mild tricuspid regurgitation.

The record contains a chest x-ray report dated July 6, 1994 from Russell County Medical Center. (EX 6) The indication for the chest x-ray was history of right middle lobe pneumonia, chronic obstructive pulmonary disease, and question occult pneumonia. The report notes mild chronic obstructive pulmonary disease, post operative changes in the right lung, no active infiltrates or effusions, and the presence of a stable calcified granuloma on the right.

Employer submitted an arterial blood gas study from the Russell County Medical Center dated January 26, 1995. The report appears in the record at EX 5. The report does not indicate for what purpose the study was originally taken; therefore, I decline to consider it as it is duplicative and its purpose is unclear. I find that it exceeds the evidentiary limitations set forth at 20 C.F.R. § 725.414 (2003).

The record contains a chest CAT scan report dated September 14, 1999 and taken at the Russell County Medical Center. It appears in the record at EX 29. The indication for the CAT scan is chest pain. Dr. Harry G. Kennedy, Jr. interpreted the scan. He stated that there is no evidence of parenchymal mass lesion within the pulmonary parenchyma or within the mediastinum and no pleural lesions are identified. He noted that mediastinal windows do not identify any evidence of pathologic mediastinal adenopathy and there is evidence of prior granulomatous disease and evidence of previous surgery. His impression is: 1) No acute chest process identified; 2) Images of upper abdomen do not demonstrate any organ abnormality except for some calcifications within the spleen felt to represent prior granulomatous disease.

Claimant was admitted to Johnston Memorial Hospital on June 21, 2001 for evaluation of weight loss and anemia. (EX 10) Following a history and physical examination, the assessment and recommendation was: 1) Anemia, hyperchromic; 2) Hematuria. The report indicates that the miner would have a CT scan of the chest as the scout film of his abdominal scan shows a change in the left side that was not present two days prior and has an uncertain etiology. A CT scan of the abdomen and pelvis showed no clear abnormalities other than slight fluid collection in the left side with fluid in the major fissure. While in the hospital, Claimant underwent a bronchoscopy with biopsy. The report appears in the record at EX 11 and the diagnosis is benign lung parenchyma with mild anthracosis, and the comment to the report states, "the lung biopsy shows mild anthracosis. There is no evidence of granulomata, chronic inflammation, or interstitial infiltrate in the submitted material." The discharge summary from this hospital admission is dated June 28, 2001 and reveals a diagnosis of pulmonary infiltrate positive for Klebsiella pneumonia, positive PPD, and positive helicobacter pylori. (EX 9)

The record contains a chest x-ray report dated July 20, 2001 from Johnston Memorial Hospital. It appears in the record at EX 2. The x-ray was taken in follow-up for pneumonia and interpreted by a board-certified radiologist named Richard Mullins. The x-ray reveals a previous right middle lobectomy and no acute processes or significant changes since a study taken July 6, 2001. Employer submitted another chest x-ray report dated June 3, 2002 and interpreted by Dr. Susan Humphreys. The report indicates that the x-ray was taken for indications of weight loss, partial gastrectomy for peptic ulcer disease; dysphagia, and small bowel abnormality. (EX 3) The impression is: 1) status post right thoracotomy; 2) development of right medial basilar consolidation due to atelectasis versus pneumonia; 3) pulmonary hyperinflation and old granulomatous disease.

The record contains a letter from Dr. Emory H. Robinette to a Dr. Swan, dated September 6, 2001. (EX 4) The letter states that Dr. Robinette saw Claimant in the hospital for follow-up of a left upper lobe pneumonia. Dr. Robinette explained that Claimant underwent a CT scan of his thorax which demonstrated interval resolution of the dense left upper lobe infiltrate of the lingual, there was no mass seen, and there were a few calcified granuloma present. He stated that he feels that the miner's pulmonary process resolved and further diagnostic workup is not necessary, and recommended that the miner receive a flu shot in the fall.

A progress note from Michael Ulrich, D.O. at Mission Health appears in the record at EX 28. The report indicates that Claimant was hospitalized from December 9-12, 2001 and is being seen in this office for follow-up after a syncopal episode with postical response consistent with seizure disorder. The assessment was apparent seizure disorder and indicated the medications and steps to control it.

Claimant was admitted to Johnston Memorial Hospital on September 19, 2002 for an elective needle biopsy of his left lower lung mass. Dr. Robinette performed a history and physical that appears in the record at DX 22. Dr. Robinette noted that Claimant has a past history of lobectomy in 1992 for squamous cell carcinoma, severe chronic obstructive pulmonary disease with a prior left upper lobe infiltrate which resolved, underlying black lung disease, a positive PPD, and history of anemia. Dr. Robinette recorded a 30 pack year cigarette smoking history and that Claimant is a retired disabled coal miner. The miner's physical exam revealed diminished breath sounds in both lung bases on auscultation with signs of consolidation of the left lower lung base. Dr. Robinette noted that extending laterally there was some dullness to the right base but there was no significant signs of consolidation noted. Claimant's cardiac exam revealed that he was somewhat tachycardic and there was a grade 2/6 systolic murmur present.

Dr. Robinette's impression was: 1) Bilateral pulmonary masses; 2) Status post right lobectomy for squamous cell carcinoma; 3) History of positive PPD with negative work-up in the past; 4) Status post gastrectomy and Billroth II anastomosis; 5) Parkinson's disease; 6) Underlying black lung disease with components of chronic obstructive pulmonary disease.

The surgical pathology report from Claimant's biopsy is dated September 19, 2002. (DX 22) The microscopic diagnosis is mass, left lung, needle biopsy: fibrosis and anthracosis with acute and chronic pneumonitis.

The record contains an operative report from Johnston Memorial Hospital for a fiberoptic bronchoscopy with bronchial washings and brushings. It is signed by Dr. Robinette and dated September 27, 2002. After introducing the scope into the trachea, Dr. Robinette described copious prurulent secretions from the right lung and examination of the right bronchial tree revealed marked anthracosis and pigmentary changes consistent with Claimant's underlying coal dust exposure. He noted bronchial wall pitting and erythema. Dr. Robinette noted no evidence of an exophytic lesion or recurrence at the prior surgical lobectomy site and examination of the left lung revealed bronchial wall pitting and anthracosis. The brushings and specimens were sent to the lab for pathological analysis.

The record contains a letter from Dr. Robinette to Dr. Michael Ulrich dated October 10, 2002. (DX 22) Dr. Robinette stated that he saw Claimant in follow-up for his 5 cm left lower lung mass, 2 cm right upper lobe mass and a history of a prior lobectomy secondary to carcinoma of the colon. He explained that Claimant's biopsy revealed fibrosis and anthracosis with evidence of chronic pneumonitis and a bronchoscopy was nondiagnostic. Dr. Robinette noted that no endobronchial lesion was identified and bronchial washings and brushings showed evidence of Hemophilus influenza infection which was treated with Levaquin. Dr. Robinette stated that he believes Claimant most likely has underlying pulmonary fibrosis and anthracosis but may have an underlying malignancy not yet diagnosed.

The record contains a fungal culture laboratory report dated October 11, 2002, that was negative. (DX 22)

A CT scan report dated November 5, 2002 appears in the record at DX 22. The CT scan was taken in follow-up of a 5 mm lung mass on previous exam. Dr. Ernest L. Coburn interpreted the CT scan and noted scarring in the lower lung zone and remarked that the well circumscribed mass along the major fissure on the left is less well circumscribed. Dr. Coburn observed linear stranding radiating from the fissure and that this has decreased slightly in size. He noted that the granuloma in the right mid lung field is unchanged. Dr. Coburn's impressions were: 1) Continued increased density along the region of the fissure on the left although it has changed somewhat in configuration; 2) Scarring in the posterior basilar segment of the RLL with some improvement compared to the previous exam; 3) Old granulomatous disease.

A progress note from Dr. Robinette, dated November 8, 2002, indicates that he saw Claimant in his office for follow-up of his lower lung mass. (DX 22). Dr. Robinette noted that Claimant's follow-up CT scan on November 5, 2002 showed a well-circumscribed mass density along the major fissure, which was less circumscribed and showed some linear stranding that was decreased in size. He noted that there was a granuloma in the right lung zone and some scarring present in the apical regions and stated that this would suggest that there has been interval improvement in the radiographic abnormalities with a decrease in the size of the primary lung lesion and evidence of old granulomatous lung disease.

The record contains a tuberculosis culture report dated November 21, 2002, which was negative. (DX 22)

A PET scan report dated December 2, 2002 appears in the record at EX 18. The report indicates that the test was performed for abnormal findings in the lung on a previous CT scan study. The report was issued by Dr. Terrell C. Estes, who is a staff radiologist at Bristol Regional Medical Center and a B reader. The report concludes that there is no abnormal increased activity identified in the right lower lobe where some increased density is observed on previous CT scan study. The report states that no abnormal increased activity is identified on PET scan imaging to correspond to the nodular appearing lesion located either within or immediately adjacent to the inferior left major fissure. Dr. Estes noted that uptake is identified in small lymph nodes of the mediastinum and both hila and in the absence of abnormal increased uptake in the remainder of this examination this will most probably prove to be a benign inflammatory basis. It is difficult to exclude the possibility of malignancy.

Claimant underwent a CAT scan at Johnston Memorial Hospital on January 8, 2003. The report appears in the record at DX 22. The CAT scan was taken in follow-up for pulmonary fibrosis and interpreted by Dr. Ernest Coburn. Dr. Coburn's impression was: 1) Calcified granuloma in the right chest; 2) Improvement of the atelectasis and/or scarring noted along the major fissure on the left and the anterior segment of the LLL; 3) Continued scarring in the posterior aspect of the right lower lung zone.

The record contains a letter from Dr. Robinette to Dr. Michael Ulrich dated February 15, 2003. (DX 22) Dr. Ulrich stated that Claimant returned to his office in follow-up for his left lung mass and has improved significantly. He noted that the recent CAT scan showed marked improvement of the atelectasis with some residual scarring in his left lower lung zone. Dr. Robinette stated that Claimant had a necrotic pneumonia in his left lower lobe which precipitated the evaluation, that he is pleased with Claimant's clinical response, and that he cannot find any evidence of malignancy at this time.

Dr. Robinette saw Claimant in follow-up again on June 2, 2003. (DX 22) He noted that a repeat CT scan demonstrated calcified granuloma in his right chest and there was improvement in the atelectasis in the left lower lobe. Auscultation revealed diminished breath sounds with poor air movement and prolongation of the expiratory phase.

A progress note from Dr. Robinette dated October 10, 2003 indicated that a repeat CAT scan failed to show any significant changes. (DX 22) Dr. Robinette noted that chest on auscultation revealed diminished breath sounds without significant bronchospasm and Claimant's chest CT scan dated October 10, 2003 demonstrated evidence of parenchymal scarring in the right upper lobe unchanged from a prior CT scan of January 8, 2003.

The record contains a progress note from an office visit to Dr. Robinette and appears in the record at CX 3. The progress note indicates that Claimant saw Dr. Robinette on December 2, 2004 for follow-up for black lung disease with associated emphysema and a calcified granuloma. Dr. Robinette noted that Claimant's weight increased to 118 pounds and that he is having persistent chest pain sounding like musculoskeletal discomfort, but denies fever, chills or other constitutional symptoms. Dr. Robinette's physical exam was essentially normal but chest auscultation revealed diminished breath sounds with poor air movement and prolongation of the expiratory phase. He noted that the heart was regular without gallop and the abdomen was soft

and nontender with no masses. Dr. Robinette noted that he added Spirova due to Claimant's increasing airflow obstruction and requested repeat pulmonary function studies and a chest CT scan for comparison to prior studies because of his increasing chest pain.

Physician Opinion Reports

Dr. Glen Baker

Dr. Baker examined Claimant on behalf of the Department of Labor. His report appears in the record at DX 10 and is dated December 11, 2003. Dr. Baker recorded a coal mine employment history as a shuttle car operator from 1966 to 1993 and he noted that Claimant reported working forty years underground. Dr. Baker recorded a family history that is positive for high blood pressure, diabetes, and cancer in his mother, heart disease, and stroke in his father, and cancer and asthma in his sister. Dr. Baker noted that Claimant's medical history consists of pneumonia, pleurisy, attacks of wheezing for ten years, chronic bronchitis for ten years, and high blood pressure for several years. He noted that Claimant also suffered from peptic ulcer disease in 1987, kidney stones, and was hospitalized for pneumonia. Dr. Baker noted that Claimant had ¾ of his stomach removed in 1997, gallbladder surgery, and surgery for calcification of the right lower lobe of the lung in 1992.

Dr. Baker recorded a cigarette smoking history that began in 1954 and stopped in 1992 and consisted of one pack per day. Dr. Baker recorded Claimant's chief complaints as daily sputum production for ten years consisting of ¼ cup in 24 hours, daily wheezing for ten years, dyspnea for ten years, daily cough for ten years, chest pain for two to three years with a negative work-up, 2 pillow orthopnea for ten years, and ankle edema for ten years. Dr. Baker also noted that Claimant complained of nighttime shortness of breath and that using an inhaler helps to alleviate it.

Claimant's physical examination was essentially normal; however, Dr. Baker found a murmur that he notes as a grade 3/6 aortic stenosis and grade 3/6 mitral insufficiency. He also noted a midline scar on Claimant's abdomen. Dr. Baker performed objective studies that included a chest x-ray interpreted as positive and 1/0, and pulmonary function, arterial blood gas studies and an EKG, all of which he noted were within normal limits. Dr. Baker indicated that Claimant has an occupational lung disease caused by his pneumoconiosis and based his diagnosis on the abnormal chest x-ray and coal dust exposure. He also indicated that Claimant has no pulmonary impairment and has the respiratory capacity to perform the work of a coal miner.

Dr. Baker listed Claimant's cardiopulmonary diagnoses as: 1) coal workers' pneumoconiosis 1/0: abnormal chest x-ray and coal dust exposure; 2) chronic bronchitis based on history; 3) chest pain by history; 4) aortic sclerosis/stenosis and mitral insufficiency—on examination. Dr. Baker listed the etiology of the cardiopulmonary diagnoses as: 1) coal dust exposure; 2) coal dust exposure/cigarette smoking; 3) ? ASHD; 4) Question etiology. He wrote the miner's impairment is "minimal with chronic bronchitis and coal workers' pneumoconiosis 1/0 " and described as "fully" the extent to which coal mine employment contributes to the impairment. Dr. Baker also noted Parkinson's disease and anemia as non-cardiopulmonary

diagnoses. Dr. Baker indicated that Claimant should be referred to another physician for further evaluation of the chest x-ray changes.

Dr. Gregory J. Fino

Dr. Fino examined Claimant on behalf of the employer on September 9, 2004. (EX 26) Dr. Fino is board certified in internal medicine, pulmonary disease, and is a B-reader. Dr. Fino noted that although Claimant uses an inhaler, he did not use any type of breathing medication during his examination. He recorded a cigarette smoking history of 1/2 pack per day for 38 years, from 1954 to 1992, and a 43-year coal mine employment history. Dr. Fino recorded that Claimant left the mines due to a layoff and his last job was as a shuttle car operator, which involved some heavy labor, although he operated the car about 75% of the working day.

Dr. Fino recorded the miner's symptoms as shortness of breath for the past fifteen years. He noted that it does not interfere with Claimant's usual daily activities, that he does not become dyspneic when walking at his own pace on the level ground or ascending one flight of steps, but dyspnea does occur when walking up hills or grades, lifting and carrying, performing manual labor, and walking briskly on level ground. Dr. Fino recorded that Claimant is limited in what he can do because of his breathing, does complain of chest pain, admits to daily cough and mucous production, does not wheeze, and there is no orthopnea or paroxysmal nocturnal dyspnea.

Dr. Fino recorded Claimant's past medical history as positive for chronic stomach problems and ulcer surgery in 1970, right lung surgery in 1992, diagnosis of Parkinson's disease in 1994, gallbladder surgery in 2001, anemia, pneumonia, hospitalization for pneumonia in 2001, emphysema, frequent headaches, and a right middle lobectomy in 1992. He noted that the miner has no history of tuberculosis, asthma, bronchitis, bronchiectasis, frequent colds, or fractured ribs. Dr. Fino recorded a family history of lung disease, heart disease, and malignancy. The miner's physical exam was essentially normal, and the lungs were clear to auscultation and percussion on a tidal volume breath and a forced expiratory maneuver without wheezes, rales, rhonchi, or rubs, and there was a right thoracotomy scar present.

Dr. Fino performed objective tests including a chest x-ray and ventilatory and arterial blood gas studies. He agreed with Dr. Wiot's classification of the chest x-ray as 0/0. He noted that Claimant did not give his best effort on the spirometry but stated that it was normal, nevertheless. Dr. Fino remarked that the FRC, RV, and the RV/TLC ratio were all elevated consistent with air trapping due to obstruction, the diffusing capacity was normal, oxygen saturation was normal, and carboxyhemoglobin level was normal. Dr. Fino noted that an exercise study was performed and that the arterial blood gases at rest and with exercise were normal without evidence of hypoxemia or oxygen transfer impairment. Dr. Fino also reviewed Claimant's medical records.

Dr. Fino's diagnoses were: 1) Previous right middle lobectomy due to pneumonia; 2) Bilateral pneumonia treated by Dr. Robinette. Dr. Fino opined that Claimant does not suffer from coal workers' pneumoconiosis because his reading of the chest x-ray and CT scans revealed no changes consistent with a coal mine dust related pulmonary condition, the acceptable spirometric evaluations are normal with no obstruction, restriction, or ventilatory impairment,

and the diffusing capacity values are normal. He explained that a normal diffusing capacity rules out the presence of clinically significant pulmonary fibrosis. Dr. Fino stated that, additionally, there is no impairment in oxygen transfer as the miner does not become hypoxemic with exercise, the TLC was not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis, and pathologically, there was no evidence of pneumoconiosis on the resected right middle lobe from 1992.

Dr. Fino stated that from a functional standpoint, Claimant's pulmonary system is normal and he retains the physiologic capacity from a respiratory standpoint to perform all the requirements of his last job, even assuming that his last job required sustained heavy labor. His reasons for this opinion are: 1) There is no ventilatory impairment as the normal spirometry clearly shows no evidence of obstruction, restriction, or ventilatory impairment; 2) The normal diffusing capacity rules out the presence of an impairment in oxygen transfer; 3) Arterial blood gases at rest and with exercise show no significant hypoxemia or any evidence of a significant impairment in oxygen transfer that would prohibit him from returning to his last mining job, and his exercise oxygenation is normal. Dr. Fino remarked that the two lung masses followed by Dr. Robinette were related to pneumonia and had nothing to do with coal mine dust inhalation and do not represent simple or complicated pneumoconiosis. Dr. Fino stated, with a reasonable degree of medical certainty, that Claimant does not suffer from a respiratory impairment or pulmonary disability due to coal mine dust inhalation, or any type of lung disease.

Dr. Fino concluded that: 1) There is insufficient objective medical evidence to justify a diagnosis of coal workers' pneumoconiosis; 2) There is no respiratory impairment present; 3) From a respiratory standpoint, Claimant is neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort; 4) Even if he were to assume Claimant has coal workers' pneumoconiosis, it has not resulted in any impairment or disability.

Dr. Fino testified in a deposition on February 28, 2005. The deposition transcript appears in the record at EX 33. Dr. Fino testified that he examined Claimant and reviewed his medical records. EX 33 at p. 6. He stated that the occupational history he received from Claimant was 43 years underground and ending in 1994 because he was laid off. EX 33 at p. 7. Dr. Fino stated that Claimant last worked as a shuttle car operator, which involved some heavy labor but that 75% of his job was driving the car and that was not heavy labor. EX 33 at pp. 7-8. Dr. Fino testified that Claimant's reported cigarette smoking history was 1/2 pack per day for 38 years, although he reported different numbers to other physicians. EX 33 at p. 8. He explained that all of Claimant's smoking histories taken by all the physicians ranged from 30 to 40 pack years. *Id.* Dr. Fino explained that Claimant's cigarette smoking history could have caused problems. EX 33 at p. 9.

Dr. Fino testified that Claimant's significant past medical history consisted of removal of a portion of the right middle lung, history of pneumonia, and Claimant's statement that he had been diagnosed with emphysema. EX 33 at p. 10. He explained that chronic right middle lobe pneumonias or acute right middle lobe pneumonias are diseases of the general medical population and are unrelated to coal dust. EX 33 at p. 11. He testified that there were no abnormalities on the miner's lung exam and that he agreed with Dr. Wiot's classification of 0/0 on Claimant's chest x-ray. EX 33 at p. 12. Dr. Fino testified that he reviewed Claimant's CT

scans and that the literature shows that a CT scan is more sensitive than a regular chest x-ray in picking out interstitial pulmonary problems or coal workers' pneumoconiosis. EX 33 at p. 14. Dr. Fino testified that he did not see any evidence of coal workers' pneumoconiosis on the CT scans. *Id.*

Dr. Fino testified that he reviewed Dr. Naeye's pathology report and explained that it is not unusual for there to be a minimal pneumoconiosis finding on a pathology review because the coal macules found are microscopic and would never be seen on a chest x-ray or CT scan. EX 33 at pp. 15-16. Dr. Fino explained that anthracosis medically is the deposition of coal pigment within the lung tissue, but in his medical opinion, that is not consistent with pneumoconiosis medically. EX 33 at p. 16. Dr. Fino testified that what Dr. Naeye described is very, very mild. EX 33 at p. 17.

Dr. Fino testified that the miner's spirometry was not a maximum effort, but it is good enough to tell him that his lung function was normal. *Id.* He explained that there was no obstruction or restriction, the lung volumes were normal and showed no evidence of fibrosis. *Id.* He stated that if Claimant had given a better effort, the values measured would have been higher. *Id.* Dr. Fino testified that there was some mild air trapping present but that is not an uncommon finding in someone who is age 68 and with Claimant's smoking history, and that air trapping is not an impairment. EX 33 at p. 18.

Dr. Fino explained that the diffusing capacity looks at the ability to transfer oxygen from the air sacks to the blood stream, and in Claimant's case, this was normal. *Id.* He further explained that a normal diffusing capacity means that there is no clinically significant emphysema or fibrosis present, such that even if pathologically there was evidence of such, it is not causing any impairment in lung function. EX 33 at pp. 18-19. Dr. Fino testified that he agrees with Dr. Castle that there was variability in Claimant's efforts during the pulmonary function studies and that the study he performed and Dr. Castle performed represent the worst Claimant could have. EX 33 at pp. 19-20. He stated that Claimant's results would have been better if he had given better efforts and that the best effort he gave was on Dr. Baker's December 11, 2003 exam and that exam was absolutely normal. EX 33 at p. 20.

Dr. Fino stated that if he were to plot the results of Claimant's pulmonary function studies on a graph it would look like a roller coaster and impairment from coal workers' pneumoconiosis is there all the time and does not improve. EX 33 at 22. He explained that the fact that Claimant's results improve support his opinion that some of the studies were invalid. *Id.* Dr. Fino testified that Claimant's arterial blood gas study was normal with no impairment in oxygen transfer or hypoxemia and this correlates well with the normal diffusing capacity. *Id.* He explained that all of the miner's resting arterial blood gas studies were consistent. *Id.* Dr. Fino testified that no other physicians performed an exercise study, but Dr. Castle got a normal diffusing capacity and a diffusing capacity is as good as an exercise blood gas test. EX 33 at pp. 22-23.

Dr. Fino testified that the five centimeter mass in Claimant's lower left lobe and the two centimeter mass in his right upper lobe noted by Dr. Robinette in 2002 do not have anything to do with pneumoconiosis. EX 33 at p. 23. He explained that the left lung mass improved

significantly, which rules out a malignancy and coal workers' pneumoconiosis, because they do not improve over time. EX 33 at p. 24. Dr. Fino testified that based on his read of the CT scan, the right upper lobe mass represents granulomatous changes and he did not see anything that would suggest coal workers' pneumoconiosis. *Id.* Dr. Fino testified that there is no evidence that coal workers' pneumoconiosis or coal dust exposure causes or aggravates or contributes to pneumonias or granulomatous disease. EX 33 at p. 25.

Dr. Fino testified that based on radiographic standards, Claimant does not have coal workers' pneumoconiosis but based on pathology standards, he does have coal workers' pneumoconiosis. *Id.* He testified that there is no evidence in the record that Claimant has complicated pneumoconiosis or progressive massive fibrosis. *Id.* Dr. Fino testified that the lung masses that exceed one centimeter did not arise out of his coal mine employment. EX 33 at p. 26. Dr. Fino testified that Claimant does not have a chronic lung disease related to or aggravated by coal dust exposure and does not have a respiratory impairment. *Id.* He testified that Claimant does have respiratory symptomology but it is not related to or aggravated by his coal dust exposure. *Id.* Dr. Fino testified that from a purely pulmonary functional standpoint, Claimant can return to work as a shuttle car operator. *Id.*

Dr. Richard L. Naeye

Dr. Naeye is board certified in anatomic and clinical pathology. He reviewed Claimant's medical records, including biopsy slides, and issued a report dated December 17, 2004. (EX 30) Dr. Naeye noted that the miner worked in underground coal mines for more than 40 years, mostly as a shuttle car operator, quitting in 1994. He noted that the miner smoked 1-2 packs of cigarettes per day for most of 38 years, consisting of a 38-76 pack year history. Dr. Naeye recorded that Claimant stopped smoking in 1992 when he had a pulmonary lobectomy for squamous cell carcinoma and the neoplasm did not recur. Dr. Naeye observed that none of the ten chest x-ray interpretations in 2003-2004 reported findings of coal workers' pneumoconiosis and one film, taken in 2002, was interpreted as 1/1 for CWP. He noted that pulmonary function studies conducted in 1993, 2003, and 2004 produced normal or near normal results.

Dr. Naeye reviewed lung biopsy slides. He stated that the first slide has a tiny bit of tissue with no distinguishing features. He described the second slide as four pieces of tissue, one of which has a small area of fibrosis with admixed black pigment and a few birefringent crystals of varying size. Dr. Naeye noted that the third slide has three tiny pieces of tissue, one of which has a small area of fibrosis with admixed black pigment and a few birefringent crystals and these findings just meet the minimum requirements for the diagnosis of simple coal workers' pneumoconiosis and their size identifies them as macules. Dr. Naeye opined that the minimum findings required to make the diagnosis of coal workers' pneumoconiosis are just met and based on the findings on chest x-rays and pulmonary function tests, the CWP is far too mild to have produced any measurable abnormalities in lung function or to have caused any disability that would prevent Claimant from returning to work mining coal. Dr. Naeye stated, based on a reasonable degree of medical certainty, that based on the findings in chest x-rays and the results of lung function studies, Claimant does not have CWP lesions that are plentiful or large enough to produce measurable abnormalities in lung function and any of these later abnormalities which are now present are due to his many years of cigarette smoking.

Dr. James R. Castle

Dr. Castle, who is board certified in internal medicine and pulmonary disease and is a B reader, examined the miner on January 11, 2005, reviewed his medical records, and issued a report that appears in the record at EX 31. Dr. Castle noted that Claimant reported right lung surgery for removal of a granuloma, and being short of breath since that time. He noted that Claimant reported being unable to walk more than about 30 feet on level ground without stopping due to shortness of breath and that he couldn't climb one flight of stairs without stopping for the same reason. Dr. Castle recorded that Claimant has a periodic productive cough since his surgery in 1992 and morning wheezing that is exacerbated by hairsprays and perfumes.

Dr. Castle noted that Claimant denied having heart trouble but experiences chest pain possibly related to exercise that resolves after about an hour, regardless of activity. He recorded that Claimant suffered from pneumonia but denied any history of asthma or tuberculosis. Dr. Castle recorded a 38 pack-year cigarette smoking history, beginning when Claimant was eighteen years old and consisting of one pack per day that ended in 1992. Dr. Castle recorded a medical history that is positive for stomach ulcer, right lung surgery to remove a granuloma, Parkinson's disease, gallbladder surgery, anemia, pneumonia, and emphysema. He noted that Claimant is allergic to dust, molds, and weeds and has a positive family history of heart disease and cancer.

Dr. Castle recorded that Claimant worked for 40 years in the mining industry, with 29 ½ years working inside the mines. He noted that Claimant stopped mining in 1993 because the mine shut down and he went to his doctor who told him that he could not go back to work. Dr. Castle recorded Claimant's last coal mine job as a shuttle car operator, which he performed about 75% of the time. He noted that the job required Claimant to haul coal from the face of the mine at the miner to the feeder and he did not have a lot of heavy labor involved and drove a machine to haul the coal. Dr. Castle noted that Claimant also worked as a trackman, jack setter, belt cleaner, and rock duster.

The miner's physical examination was essentially normal. Dr. Castle recorded that the chest exam revealed a thin chest with moderately increased AP diameter, no intercostals retractions, and no use of the accessory muscles with quiet breathing. Dr. Castle described the miner's breath sounds as present and equal throughout and noted that he had some diminution of the breath sounds, with no rales, rhonchi, wheezes, rubs, crackles, or crepitations. Dr. Castle noted that the cardiac exam revealed PMI to be diffuse, S1 and S2 were normal, and he had a grade II-II/VI systolic murmur at the upper right sternal border with radiation toward the neck and clavicle on the right side. Dr. Castle heard no diastolic murmurs. He noted that the abdominal exam revealed an old, well healed subcostal scar and had no organomegaly, masses, tenderness, or bruits and the extremities revealed no cyanosis, clubbing, or edema.

Claimant underwent a chest x-ray interpreted by Dr. Wheeler, which is set forth above. Dr. Castle reviewed a CT scan of Claimant's chest dated 9/14/99 from Russell County Medical Center and stated that the changes on that scan are the same as those present on a scan taken 8/4/04. (EX 32) He stated that he did not find evidence of coal workers' pneumoconiosis and

there is evidence of atherosclerosis involving the thoracic aorta. Dr. Castle performed a pulmonary function study which showed evidence of a mild reduction in the forced vital capacity and FEV1 without large airway obstruction, restriction, or diffusion abnormality. Dr. Castle performed an arterial blood gas study and noted that Claimant's hemoglobin was reduced. He indicated that Claimant did not undergo exercise testing because his legs would not "hold up" and allow him to walk on a treadmill. Dr. Castle also performed an electrocardiogram.

After reviewing all the data from his examination of Claimant, Dr. Castle opined that there is:

1) No evidence of coal workers' pneumoconiosis by physical examination, radiographic evaluation, physiologic testing, and arterial blood gases;
2) Mild reduction in the forced vital capacity and FEV1 without evidence of disabling obstruction, restriction, or diffusion abnormality;
3) History of surgery for granulomatous disease;
4) Possible aortic stenosis;
5) Abnormal electrocardiogram;
6) History of Parkinson's disease;
7) Anemia (and history of anemia);
8) History of previous peptic ulcer disease.

After reviewing all the additional medical data and his own data, Dr. Castle opined, within a reasonable degree of medical certainty, based on the medical histories, physical examinations, radiographic evaluations, physiologic testing, arterial blood gas studies, hospital records, biopsy material, and other data, that Claimant does have evidence of minimal, simple coal workers' pneumoconiosis. Dr. Castle explained that Claimant worked in or around underground mining for a sufficient enough time to have developed coal workers' pneumoconiosis if he were a susceptible host. He explained that another risk factor for development of pulmonary disease is Claimant's tobacco abuse and his cigarette smoking history is a sufficient enough time to have caused him to develop chronic obstructive pulmonary disease; i.e., chronic bronchitis/emphysema and/or lung cancer and/or atherosclerotic cardiovascular disease if he were a susceptible host.

Dr. Castle stated that another risk factor for the development of pulmonary symptoms is cardiac disease and Claimant has a history of a cardiac murmur consistent with aortic stenosis, which can result in significant shortness of breath due to that process. He explained that another risk factor for pulmonary symptoms is chronic anemia and that Claimant has a history of chronic anemia over a number of years, which can cause fatigue, weakness, and result in shortness of breath with exercise. Dr. Castle observed that Claimant did not have consistent physical findings indicating presence of an interstitial pulmonary process and did not have consistent findings of rales, crackles, or crepitations.

Dr. Castle explained that it is his opinion and also the opinion of the vast majority of radiologists and B readers that there was no evidence of pneumoconiosis radiographically and that was further confirmed by CT scans that were not reported as showing evidence of pneumoconiosis. He explained that the valid physiologic studies did not show evidence of a

disabling respiratory impairment from any cause and at the time of his own examination, Claimant did not demonstrate any obstruction, restriction, or diffusion abnormality. Dr. Castle stated that the arterial blood gas studies that were taken during periods of wellness were normal and when exercise tests were taken, he had a normal response and they were normal as well. He noted that Claimant did not demonstrate a disabling abnormality of blood gas transfer mechanisms. Dr. Castle explained that Dr. Naeye's review of the biopsy material indicated the minimum criteria for a diagnosis of simple coal workers' pneumoconiosis was met and therefore, it is his opinion that Claimant does have pathologic evidence of minimal, simple coal workers' pneumoconiosis.

Dr. Castle opined, with a reasonable degree of medical certainty, that Claimant is not permanently and totally disabled as a result of coal workers' pneumoconiosis and that he does retain the respiratory capacity to perform his previous coal mine employment duties. He opined that Claimant is very likely permanently and totally disabled as a result of age, Parkinson's disease, possible valvular heart disease, and anemia, which are all conditions of the general public at large and are unrelated to coal mine dust exposure and coal workers' pneumoconiosis.

Dr. Castle testified in a deposition on May 6, 2005 and the deposition transcript appears in the record at EX 35. Dr. Castle testified that he examined Claimant and reviewed his medical records. EX 35 at pp. 5-6. He stated that Claimant reported working 40 years in the mining industry, received credit for 29 1/2 years, and stopped working in 1993 after the mine shut down. EX 35 at p. 6. Dr. Castle testified that Claimant reported his last job was a shuttle car operator and that his doctor told him he could not go back to work. *Id.* Dr. Castle stated that Claimant indicated that he did not have a lot of heavy labor and basically drove a machine to haul the coal from the face of the mine to the feeder. *Id.* Dr. Castle testified that Claimant's description of the shuttle car operator position is consistent with descriptions he has gotten from other miners in that position and is consistent with what he has personally seen shuttle car operators perform when he has visited the mines. EX 35 at p. 7. Dr. Castle testified that he understood Claimant would also perform intermittent heavy labor. *Id.*

Dr. Castle testified that Claimant reported starting smoking cigarettes at age eighteen and stopped smoking in 1992, after smoking one pack of cigarettes per day, which would give him a 38 pack-year history. EX 35 at pp. 7-8. He explained that this is a sufficient enough history for Claimant to have developed either chronic airway bronchitis, lung cancer, or atherosclerotic cardiovascular disease if he were a susceptible person. EX 35 at p. 8. Dr. Castle testified that Claimant reported right lung surgery and removal of a granuloma, shortness of breath, could presently only walk 30 feet without stopping, could not climb one flight of stairs, cough with sputum, and morning wheezing. *Id.* Dr. Castle testified that Claimant had a right middle lobectomy for a necrotic pneumonia and explained that it is not related to coal dust exposure because this type of pneumonia can occur in a person who does not heal from a regular pneumonia or is infected with another organism that doesn't heal properly, resulting in a chronic inflammatory process. EX 35 at p. 9. Like Dr. Fino, Dr. Castle explained that the pneumonia will have to be removed in order to distinguish it from cancer. *Id.*

Dr. Castle testified that he reviewed Claimant's echocardiogram, which showed mild to moderate left ventricular dysfunction consistent with previous myocardial infarction, as well as

mild mitral regurgitation and mild tricuspid regurgitation. EX 35 at p. 11. He explained that the evidence of left ventricular dysfunction from the heart attack is a significant problem but the heart findings are not in any way related to coal dust exposure. *Id.* Dr. Castle testified that when he examined Claimant, his breath sounds were somewhat diminished but he heard no rales, crackles, crepitations, or wheezes and he did hear a Grade II-III/VI systolic murmur at the right upper sternal border with radiation towards the neck and clavicle on the right side, which could be a murmur of aortic stenosis. EX 35 at p. 12.

Dr. Castle testified that Claimant underwent a chest x-ray that was interpreted by Dr. Wheeler, who found no evidence of pneumoconiosis and he agrees with Dr. Wheeler's assessment. EX 35 at p. 13. Dr. Castle testified that he reviewed Claimant's CT scans taken 9/14/99 and 8/4/04 and found no evidence of pneumoconiosis but found evidence of old granulomatous disease, previous thoracic surgery, and atherosclerosis involving the aorta. EX 35 at p. 14. Dr. Castle testified that he reviewed Dr. Naeye's biopsy report and that Dr. Naeye's minimum findings of coal workers' pneumoconiosis are consistent with the negative chest x-rays and CT scans. EX 35 at p. 17. He explained that when there are changes in biopsy that are as minimal as what Dr. Naeye found, he would not expect to find either changes on chest x-ray or CT scan. EX 35 at pp. 17-18.

Dr. Castle testified that he diagnosed Claimant with coal workers' pneumoconiosis. EX 35 at p. 18. He testified that Claimant's effort on the spirometry was variable but his valid efforts showed evidence of very mild reduction in the FVC and FEV1 without large airway obstruction and he had no restriction or diffusion abnormality. *Id.* Dr. Castle explained that the spirometry in the record varied from valid results to invalid results and that when the best efforts exceed disability levels and there are invalid results, it represents the least Claimant could do and that he could in fact do better. EX 35 at p. 20. He stated that from this, one could determine that Claimant is not disabled since a person can't artificially increase their lung function. EX 35 at pp. 20-21.

Dr. Castle testified that the variability of the results in the different pulmonary function studies is not a pattern that is consistent with coal workers' pneumoconiosis because it is a persistent, fixed disease that does not get better with time or treatment, so you wouldn't see a waxing or waning of any of the values. EX 35 at p. 21. He stated that this would tell him, if all of the studies were valid, that Claimant had some other type of disease process that was occurring intermittently and resolving in between. *Id.* Dr. Castle testified that Claimant's arterial blood gas study was normal and he did not exercise him because his EKG was abnormal, he had a heart murmur, and Claimant didn't think that his legs would hold up. EX 35 at pp. 21-22.

Dr. Castle testified that Claimant's hemoglobin level was low and explained that this could cause problems in the amount of oxygen carried in the blood. EX 35 at pp. 22-23. He stated that lowered hemoglobin is not related to coal dust exposure. EX 35 at p. 23. Dr. Castle testified that based on the studies he performed and reviewed, at the very worst Claimant might have a very mild, clinically insignificant impairment, but if there were valid studies, he probably wouldn't have any at all. *Id.*

Dr. Castle testified that there was no evidence that the five-centimeter mass in Claimant's lower left lung and the two-centimeter mass in Claimant's right upper lung, as noted by Dr. Robinette, were related to coal dust exposure or pneumoconiosis. EX 35 a p. 24. He explained that Dr. Robinette indicated that the masses had resolved and were probably due to pneumonia and did not consider the diagnosis of complicated disease. *Id.* Dr. Castle stated that based upon his examination of Claimant and his review of the medical records, it is his opinion that the miner does have pathologic evidence of minimal simple coal workers' pneumoconiosis. *Id.*

Dr. Castle testified that it is his opinion that Claimant does not suffer from progressive massive fibrosis, complicated coal workers' pneumoconiosis, or a chronic dust disease of the lung due to his coal mining employment. EX 35 at p. 25. Dr. Castle testified that Claimant might have a very mild, clinically insignificant impairment but most likely does not. *Id.* He explained that an impairment, if any, is not related to coal mine dust exposure. EX 35 at p. 26. He testified that although the miner does have respiratory symptoms, they are not sufficient to keep him from performing his previous coal mining job, nor are his symptoms related to coal dust exposure, and based upon his physiologic testing, he could certainly do his previous job in the coal mines. EX 35 at pp. 25-26. Dr. Castle testified that if Claimant had never worked in the mines he would be in the same respiratory condition that he is in now. EX 35 at p. 26.

Conclusions of Law

Length of Coal Mine Employment

The parties stipulated and I find that Claimant was a coal miner within the meaning of the Act for 29.53 years. Tr. 6.

Date of Filing

I find that Claimant filed his claim for benefits under the Act on October 10, 2003. (DX 2)

Responsible Operator

Clinchfield Coal Company is the last employer for whom Claimant worked a period of at least one year and is the properly designated responsible operator pursuant to 20 C.F.R. §§ 725.494-725.495 (2001). Clinchfield Coal Company has not established that another operator is liable for the payment of benefits. 20 C.F.R. §725.495(c)(1) and (2)(2001).

Dependents

I find that Claimant has one dependent, his wife, Millie, for purposes of augmentation of benefits under the Act. (DX 8, Tr. 5)

Standard of Review

The administrative law judge need not accept the opinion of any particular medical witness or expert, but must weigh all the evidence and draw his/her own conclusions and inferences. *Lafferty v. Cannelton Industries, Inc.*, 12 B.L.R. 1-190 (1989); *Stark v. Director, OWCP*, 9 B.L.R. 1-36 (1986); *Todd Shipyards Corp. v. Donovan*, 300 F.2d 741 (5th Cir. 1962). The adjudicator's function is to resolve the conflicts in the medical evidence; those findings will not be disturbed on appeal if supported by substantial evidence. *Lafferty, supra*; *Fagg v. Amax Coal Co.*, 12 B.L.R. 1-77 (1988); *aff'd*, 865 F.2d 916 (7th Cir. 1989); *Short v. Westmoreland Coal Co.*, 10 B.L.R. 1-127 (1987); *Piccin v. Director, OWCP*, 6 B.L.R. 1-616 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983).

In considering the medical evidence of record, an administrative law judge must not selectively analyze the evidence. *See Wright v. Director, OWCP*, 7 B.L.R. 1-475 (1984); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Crider v. Dean Jones Coal Co.*, 6 B.L.R. 1-606 (1983); *Peabody Coal Co. v. Lowis*, 708 F.2d 266, 5 B.L.R. 2-84 (7th Cir. 1983); *see also Stevenson v. Windsor Power House Coal Co.*, 6 B.L.R. 1-1315 (1984). The weight of the evidence, and determinations concerning credibility of medical experts and witnesses, however, is for the administrative law judge to determine. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986); *Brown v. Director, OWCP*, 7 B.L.R. 1-730 (1985); *see also Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985); *Henning v. Peabody Coal Co.*, 7 B.L.R. 1-753 (1985); *Peabody Coal Co. v. Benefits Review Board*, 560 F.2d 797, 1 B.L.R. 2-133 (7th Cir. 1977).

As the trier-of fact, the administrative law judge has broad discretion to assess the evidence of record and determine whether a party has met its burden of proof. *Kuchwara v. Director, OWCP*, 7 B.L.R. 1-167 (1984). In considering the evidence on any particular issue, the administrative law judge must be cognizant of which party bears the burden of proof. Claimant has the general burden of establishing entitlement and the initial burden of going forward with the evidence. *See White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The Existence of Pneumoconiosis

The claimant has the burden of proving the existence of pneumoconiosis by any one of four methods: (1) a chest x-ray meeting the criteria set forth in 20 C.F.R. § 718.202(a); (2) a biopsy or autopsy conducted and reported in compliance with 20 C.F.R. § 718.106; (3) application of the irrebuttable presumption for "complicated pneumoconiosis" found in 20 C.F.R. § 718.304; or (4) a determination of the existence of pneumoconiosis made by a physician exercising sound judgment, based upon certain clinical data and medical and work histories, and supported by reasoned medical opinion. 20 C.F.R. § 718.202(a). All types of relevant evidence must be weighed together in determining whether a claimant has pneumoconiosis. *Island Creek Coal Company v. Compton*, 211 F.3d 203 (4th Cir. 2000).

Chest X-ray Evidence

A finding of the existence of pneumoconiosis may be made with positive chest x-ray evidence. 20 C.F.R. § 718.202(a)(1). The existence of pneumoconiosis may be established by

chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. A chest x-ray classified as category 0, including subcategories 0/-, 0/0, 0/1 does not constitute evidence of pneumoconiosis. 20 C.F.R. § 718.102(b). Because pneumoconiosis is a progressive and irreversible disease, it may be appropriate to accord greater weight to the most recent evidence of record. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986).

Where two or more x-ray reports are in conflict, the radiographic qualifications of the physicians interpreting the x-rays must be considered. 20 C.F.R. § 718.201(a)(1). The interpretations of physicians who are dually-qualified (board-certified radiologists and B-readers) are entitled to the greatest weight. The Benefits Review Board held that it is proper to credit the interpretation of a dually-qualified physician over the interpretation of a B-reader. *Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999)(en banc on recon.).

Of the submitted evidence, there were ten interpretations of five chest x-rays, with five positive interpretations and five negative interpretations. Of these ten interpretations, there was one positive interpretation by a B-reader, and four positive interpretations by dually-qualified physicians. By contrast, there were five negative interpretations by dually-qualified physicians. The most recent chest x-ray, taken in January 2005, was interpreted as positive by one dually-qualified physician and interpreted as negative by another dually qualified physician. As the chest x-ray evidence is in equipoise and more dually-qualified physicians rendered negative chest x-ray interpretations than positive interpretations, I find that Claimant has not established the presence of pneumoconiosis with the chest x-ray evidence.

Biopsy Evidence

Pursuant to 20 C.F.R. § 718.202(a)(2), a claimant may establish pneumoconiosis through the use of biopsy evidence. Claimant underwent three lung biopsies and two biopsies revealed fibrosis and mild anthracosis. A finding in a biopsy of anthracotic pigmentation is not sufficient, by itself, to establish the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2)(2001). However, Dr. Naeye, a reviewing pathologist, also noted a small area of fibrosis with admixed black pigment and a few birefringent crystals. He identified these crystals as coal macules, stated that they meet the minimum requirements for a finding of pneumoconiosis, and diagnosed minimal coal workers' pneumoconiosis. Accordingly, I find that Claimant has established the presence of pneumoconiosis with the biopsy evidence.

Complicated Pneumoconiosis

There is no evidence that the miner suffers from large opacity, complicated pneumoconiosis; therefore, he is not entitled to the irrebuttable presumption set forth at 20 C.F.R. § 718.304.

Medical Opinion and CT Scan Evidence

Medical reports that are based upon and supported by patient histories, a review of symptoms, and a physical examination, constitute adequately documented medical opinions as

contemplated by the Regulations. *Justice v. Director, OWCP*, 6 B.L.R. 1-1127 (1984). However, where the physician's report, although documented, fails to explain how the documentation supports its conclusions, an administrative law judge may find the report is not a reasoned medical opinion. *Smith v. Eastern Associated Coal Co.*, 6 B.L.R. 1-1130 (1984). A medical opinion shall not be considered sufficiently reasoned if the underlying objective medical data contraindicates it. *White v. Director, OWCP*, 6 B.L.R. 1-368 (1983).

The reports of four physicians were submitted regarding Claimant's medical condition. Drs. Baker, Naeye, and Castle opined that Claimant suffers from coal workers' pneumoconiosis. Dr. Fino opined that the miner does not suffer from coal workers' pneumoconiosis. All of the physicians reviewed the miner's medical records and all of the physicians but Naeye, who is a pathologist, also examined the miner and performed objective tests. I find that all of their opinions are well-documented.

Dr. Baker based his opinion on Claimant's positive chest x-ray and occupational coal dust exposure history. Unlike Drs. Fino, Naeye, and Castle, Dr. Baker did not have access to Claimant's biopsy reports and Dr. Naeye's review of the biopsy slides. Nevertheless, Dr. Baker's opinion is well-reasoned because he based his opinion on the objective studies, physical examination, and Claimant's occupational and social histories and his opinion is supported by the underlying objective evidence and better reasoned medical opinions.

Dr. Fino opined that there is not sufficient objective evidence to justify a diagnosis of coal workers' pneumoconiosis or any chronic dust disease of the lung related to the miner's coal mine employment. In arriving at this conclusion, Dr. Fino testified that the x-ray evidence shows that there is not coal workers' pneumoconiosis radiologically, that he did not see any evidence of coal workers' pneumoconiosis on CT scan, and that although anthracosis is the deposition of coal pigment within the lung tissue, what Dr. Naeye described is very, very mild and in his opinion, not consistent with pneumoconiosis medically. This observation is without merit. First, there is no requirement that coal workers' pneumoconiosis be in an advanced stage in order to validate its existence. Moreover, as I previously found, the biopsy evidence as interpreted by Dr. Naeye revealed coal macules large enough for him, as a pathologist, to render a diagnosis of coal workers' pneumoconiosis. Although I found that the chest x-ray evidence was not sufficient for Claimant to establish the existence of pneumoconiosis, I note that several dually-qualified physicians diagnosed coal workers' pneumoconiosis by chest x-ray and that the chest x-ray evidence was very close. Moreover, Dr. Fino acknowledged that it is not unusual for pneumoconiosis to be found by biopsy but not seen on chest x-ray or CT scan. Dr. Fino also neglected to discuss how he ruled out Claimant's extensive occupational history in forming his opinion. Accordingly, I find that Dr. Fino's opinion is not well-reasoned and entitled to little weight.

Dr. Naeye, a pathologist, reviewed the miner's medical records, occupational and social histories, and biopsy slides and identified the black pigment and birefringent crystals on the slides as macules. He opined that the size of the macules meets the minimum definition of pneumoconiosis. As Dr. Naeye's opinion is supported by his review of the biopsy slides, I find that it is well reasoned.

Dr. Castle opined that Claimant does have evidence of minimal, simple coal workers' pneumoconiosis. He based his opinion on his examination of the miner, his review of the medical records, objective studies, Claimant's occupational and social histories, and the biopsy materials. Dr. Castle thoroughly explained the basis for his opinion and stated that although the chest x-rays, CT scans, and his own physical examination of the miner did not indicate the presence of pneumoconiosis, the biopsy material demonstrates that Claimant does have pathologic evidence of simple coal workers' pneumoconiosis and his occupational exposure was sufficient enough for him to develop the disease if he was susceptible to it. As Dr. Castle's opinion is the most thoroughly reasoned of the medical opinions, it is entitled to great weight.

There are two CAT scans, two CT scans and a PET scan in the record. None of the scans were taken for the purpose of diagnosing coal workers' pneumoconiosis, although Drs. Fino and Castle interpreted the two CT scans as negative for pneumoconiosis. Both physicians, however, explained that because the evidence on the biopsy slides is microscopic, it is not uncommon for coal workers' pneumoconiosis to be diagnosed on biopsy but not seen on chest x-ray or CT scan. In addition, both Dr. Naeye and Dr. Castle opined that Claimant suffers from minimal coal workers' pneumoconiosis notwithstanding the CT scans. Therefore, I find that their opinions outweigh the negative CT and other scans.

Weighing the recent medical opinion evidence together, including the CT and other scan evidence, I find that the better-reasoned opinions of Drs. Castle, Baker, and Naeye outweigh the opinion of Dr. Fino and that Claimant has established the presence of coal workers' pneumoconiosis with the medical opinion evidence at 20 C.F.R. § 718.202(a)(4).

Pursuant to the holding in *Compton*, *supra*, I must weigh all of the evidence under 20 C.F.R. § 718.202(a) together in order to make a determination regarding the existence of pneumoconiosis. I previously found that Claimant established the existence of pneumoconiosis through the biopsy evidence and the medical opinion evidence at §§ 718.202(a)(2) and 718.202(a)(4). I also found that the chest x-ray evidence and CT scan evidence did not establish the existence of pneumoconiosis; however, the physicians explained that because simple coal workers' pneumoconiosis can be microscopic, it can also be present but not seen on chest x-ray or CT scan. Finally, I found that the best reasoned medical opinion took into consideration the negative chest x-rays and CT scans and still found the presence of pneumoconiosis based upon the biopsy and occupational history. Accordingly, weighing all of the evidence together, I find that Claimant has established the existence of pneumoconiosis pursuant to § 718.202(a) and *Compton*.

Cause of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. Twenty C.F.R. § 718.203(a)(2001) provides that if a miner who is suffering from pneumoconiosis was employed for ten or more years in the coal mines, there shall be a rebuttable presumption that the pneumoconiosis arose out of that coal mine employment.

I find that Claimant, with at least 29 years of coal mine employment, is entitled to the rebuttable presumption at § 718.203. Moreover, I previously found that Dr. Fino's opinion was poorly reasoned because he did not explain why he discounted the miner's substantial coal mine employment history in concluding that he did not suffer from pneumoconiosis. For these reasons, I find that Employer has not submitted sufficient evidence to rebut this presumption.

Evidence of Total Disability and Disability Causation

Claimant must also prove that he is totally disabled due to pneumoconiosis. Total disability is defined as pneumoconiosis that prevents or prevented a miner from performing his usual coal mine employment or other comparable gainful work. 20 C.F.R. §§ 718.305(c), 718.204(b)(1). A finding of total disability may be based on the criteria found in § 718.204(b)(1), which provides that a miner will be considered totally disabled if the irrebuttable presumption set forth in § 718.304 applies,[5] or may be established by the criteria set forth in § 718.204(b)(2), which consists of qualifying pulmonary function studies, qualifying blood gas studies, the existence of cor pulmonale with right sided congestive heart failure, and the opinion of a physician, exercising sound medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concluding that the miner's pulmonary condition prevents him from performing his usual coal mine work.

I previously found that Claimant is not entitled to the irrebuttable presumption set forth in § 718.304. In addition, there is no evidence that he suffers from cor pulmonale with right-sided congestive heart failure.

There are five pulmonary function studies in the record. Two of the studies produced qualifying values and three of the studies did not. Both of the qualifying studies were followed by non-qualifying studies and the most recent studies were non-qualifying. As the majority of the studies are non-qualifying, and the most recent studies are non-qualifying, I find that Claimant failed to establish total disability pursuant to the pulmonary function study evidence at § 718.204(b)(2)(i)(2003).

There are three arterial blood gas studies in the record, none of which are qualifying. Accordingly, I find that Claimant has not established total disability pursuant to § 718.204(b)(ii)(2).

There are four physicians who have rendered an opinion relative to this issue. Drs. Baker, Fino, and Castle opined that Claimant has the respiratory capacity to perform the work of his previous coal mine employment or similar work. As all of these physicians were familiar with the demands of Claimant's previous employment, and they based their opinions on the objective evidence, physical examination of the miner, and his occupational history, I find that their opinions are well-documented and well-reasoned. Dr. Naeye opined that Claimant does not have coal workers' pneumoconiosis lesions that are plentiful or large enough to produce measurable abnormalities in lung function. Because Dr. Naeye did not discuss Claimant's lung

[5] There is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis if a chest x-ray yields one or more large opacities (greater than 1 centimeter) and would be classified as Category A, B, or C as further specified in the Regulation.

function in relation to his coal mine work, I find that his opinion is entitled to less weight than the other physicians.

Based on the above, weighing the physician opinion reports together, I find that Claimant has not established, by a preponderance of the medical opinion evidence, that he is totally disabled from performing his previous coal mine work or comparable work pursuant to 20 C.F.R. § 718.204(b)(2)(iv)(2003).

Weighing the pulmonary function study evidence, the arterial blood gas study evidence, and the physician opinion evidence together, I find that Claimant has not established that he is totally disabled from performing his usual coal mine work. In addition, because Claimant has not established that he is totally disabled, he cannot establish disability causation.

Conclusion

As Claimant failed to establish all of the requisite elements of entitlement, I find that he is not entitled to benefits under the Act.

ORDER

The claim of Harold D. Stevens for black lung benefits under the Act is hereby denied.

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STEPHEN L. PURCELL
Administrative Law Judge

Washington, D.C.

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the Office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, D.C. 20013-7601*. A copy of a notice of appeal must also be served on Allen Feldman, Esq., Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, N.W., Washington, D.C. 20210.